

CLAIM AGAINST COUNTY OF SAN BERNARDINO
(CLAIM FORM MUST BE FILLED OUT PROPERLY OR CLAIM WILL BE RETURNED WITHOUT FILING)



DATE: _____

Claim is hereby made against the treasury of the County of San Bernardino, State of California, as follows:

- Less than \$10,000 – State the total amount claimed \$ _____
- More than \$10,000 – Check one of the boxes:
☐ Municipal Court Jurisdiction (\$10,000 - \$25,000) ☐ Superior Court Jurisdiction (\$25,001 and up)

Claimant makes the following statements in support of the claim:

1. Name of Claimant: _____

First Middle Last (Area Code and Phone No.)
2. Address of Claimant: _____

Street City Zip Code
3. Notices concerning claim should be sent to:

Name Address Zip Code (Area Code and Phone No.)
4. Circumstances giving rise to claim are as follows: _____

5. Date, Time and Place (city, street, cross-street) damage occurred and nature thereof: _____

6. Public property and/or public officers or employees causing injury, damage or loss:

7. Name, address and telephone number of witnesses: _____

8. Basis of computation of claimed amount is as follows:

Medical expenses to date _____	Loss wages _____
Estimated future medical expenses _____	General damages _____
Other expenses _____	Property damage _____
Other damages _____	

Claimant or Representative (Signature)

RETURN COMPLETED FORM TO:

Risk Management Division – County of San Bernardino, State of California
222 W. Hospitality Lane, 3rd Floor
San Bernardino, CA 92415-0016

Office: (909) 386-8631
Fax: (909) 386-8670